

LETTERS TO THE EDITOR

Surgery and benign facial lesions

EDITOR,—It is not uncommon for general practitioners and surgeons to be approached by parents whose children have small lesions on their faces, present often from birth and causing little in the way of problems. These lesions are often small haemangiomas that regress with time.¹ Reassurance is important and surgery often unnecessary.

Case reports

During a three month period in 1992, three children under the age of 1 year presented to our unit, bleeding from small haemangiomas on their faces. All the lesions had been present from birth and in none was there a history of bleeding. All three lesions had been bleeding intermittently for 12–24 hours by the time the children reached the unit.

In all three cases the children had local excision and diathermy to the bleeding point at the base of the lesions within one hour of admission, conservative measures such as the application of silver nitrate sticks having failed. One child required a blood transfusion for acute blood loss.

There were no postoperative problems and all three children were discharged the next morning.

Discussion

The blood volume of a 10 kg child is 800 ml. It is commonly accepted that, at this age, an

acute blood loss of 10–15% of blood volume requires resuscitative measures.²

If one assumes that 1 ml of blood is contained within 15 drops, then 80 ml (10% of blood volume) is equal to 1200 drops. If one then approximates and says that a small lesion, such as we have described, bleeds at two drops per minute, then one can understand that it will only take 10 hours for a 10 kg child to lose 10% of its blood volume.

It is therefore essential for children presenting with such lesions which are bleeding to be dealt with *as soon as possible*, before the blood volume has been reduced to the extent that intravenous blood or plasma replacements have to be given. If conservative measures fail, surgery in the acute stage is mandatory. As these lesions are often small and the blood loss apparently slow, this point is sometimes difficult to appreciate.

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1 McKee PH. *Pathology of the skin*. Philadelphia: Lippincott. 1989: 16.50–16.52.

2 Vaughan VC, McKay RJ, Nelson WE, eds. *Anemias. Nelson textbook of pediatrics*. 14th Ed. Philadelphia: WB Saunders, 1992: 1229–61.

Munchausen syndrome

EDITOR,—Professor Meadow recently published his article on Munchausen syndrome by proxy,¹ and previously other communications on Munchausen's syndrome have appeared (for example, Ifudu *et al*²).

All these publications refer to the first description of the syndrome by R Asher,³ who is responsible for misspelling Münchhausen

in Anglo-American medical literature over the past 42 years! Asher spelt Münchhausen as Munchausen and all subsequent English speaking authors have copied the wrong spelling. Isn't it time that this error was rectified?

The syndrome was named after Baron Karl Friedrich Hieronymus Freiherr von Münchhausen, who lived from 1720 to 1797 and became famous as a narrator of fantastic stories.

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1 Meadow R. False allegations of abuse and Munchausen syndrome by proxy. *Arch Dis Child* 1993; 68: 444–7.

2 Ifudu O, Kolasinski SL, Friedman EA. Brief report: kidney-related Munchausen's syndrome. *N Engl J Med* 1992; 327: 388–9.

3 Asher R. Munchausen's syndrome. *Lancet* 1951; i: 339–41.

Professor Meadow comments:

Though the real Baron Münchhausen of Bodenwerder near Hannover spelt his name with two 'h's' and an umlaut, the fictitious Baron did not. *Baron Munchausen's narrative of his marvellous travels and campaigns in Russia* written by R E Raspe, and first published in London (in the *English* language) in 1785, had the anglicised spelling. Richard Asher dedicated his syndrome to the fictitious Baron – hence one 'h' and no umlaut.

Further reading

Meadow R, Lennert T. Munchausen by proxy or Polle syndrome: which term is correct? *Pediatrics* 1984; 74: 554–6.